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ABSTRACT

Although many school psychology programs use university-based clinics as field placements for school psychology students, there is little information in the literature on how these clinics are organized, administered, and funded or on the nature, duration, and sequencing of clinic field experiences. A national telephone survey of 71 directors of clinics that serve as practicum and internship sites for school psychology students was conducted to examine the organization and training practices of university clinics affiliated with school psychology programs. A structured questionnaire was used which addressed the areas of administration, funding, facilities, staffing, client population, coordination with other clinics on campus, contractual arrangements, supervision, multidisciplinary involvement, fees, types of field experiences, and duration and sequencing of the clinic experience. Survey results indicated that school psychology practicum experience in a university-based clinic is a common training practice, and is used most frequently in doctoral programs. Many differences were found in how clinics were administered, funded, and staffed as well as in the extent of clinic experience required of students. A wide variety of models and practices were found in the provision of university-based clinical field experiences, reflecting differences in program and university resources, administrative structures, program training goals, community resources, faculty interests and competencies, and the availability of alternate field placements. Results are reported both in terms of the percentages of programs reporting different practices and in specific, illustrative practices in providing clinic-based training experiences to school psychology students. (NRB)

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University Clinics as Field Placements in School Psychology Training: A National Survey

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Running Head: UNIVERSITY CLINICS

Abstract

University Clinics as Field Placements in School Psychology Training: A National Survey

Of 208 school psychology programs in the United States, 193 programs responded to an initial letter requesting program directors to return a postcard questionnaire indicating if the program utilized a university based clinic as a field placement for school psychology students. Of the 92 programs (48%) reporting use of such a clinic, 71 (77%) completed a lengthy follow-up questionnaire. Sixty of these questionnaires were completed in a telephone interview, and eleven were completed by mail. The questionnaire addressed administrative/organizational issues (e.g., administration, funding, facilities, staffing, client population, coordination with other clinics, fees) and training issues (e.g., supervisory practices, multi-disciplinary involvement, and the nature, duration, and sequencing of field experiences). Results are reported in terms of the percentage of programs reporting different practices. Specific illustrative practices in providing clinic based field experiences to school psychology students are also presented, and common issues in this model of providing field experiences are discussed.

University Clinics as Field Placements in School Psychology Training: A National Survey

Historical Overview

French's claim that the practice of school psychology began in 1896 is based on the establishment that year by Lightner Witmer of the first psychological clinic in the United States at the University of Pennsylvania (French, 1984). The clinic was founded for the study and treatment of atypical children, especially mentally retarded children, but including children who today would be characterized as learning disabled, emotionally disturbed, and physically impaired (Collins, cited in French, 1984). The history of the first half century of both clinical and school psychology is, in large part, the history of university psychological clinics. (Fagan, in press, French, 1984).

The university-based clinic was of crucial importance to the applied training of students in the emerging graduate programs offering preparation for school psychologists in the 1930's - 1960's (Fagan, in press; French, 1984). Psychologists who were trained in these early university clinics established similar clinics and applied psychology training programs at other universities (Fagan, in press). Although these training programs before the 1940's were not, generally, formally recognized as school psychology programs, they offered coursework and field experiences for persons who provided psychological services in the schools (Fagan, in press). In 1936 the first State Education Agency guidelines for training of psychologists in the schools were put into place (French, 1984). In that same year there were 87 psychological clinics affiliated with colleges and Universities (Reisman, cited by French, 1984). The University clinic

was the primary facility delivering broadly defined clinical and educational services to atypical children and their families from the early 1900's until at least the 1940's (Wallin, 1942). As certification became more common, training programs became more formalized (Fagan, in press).

Until the early 1960s, psychoeducational services to children with learning or adjustment problems and counseling services to college students were the primary services provided by university clinics. (Goodstein, 1973). Pryzwansky (1971) cited three reasons for the common practice by school psychology training programs of placing school psychology students in university clinics for their field experience. First, qualified on-site supervisors were rarely available in the schools. Second, parttime school psychology students required a field placement that allowed more flexible hours than possible in schools. Third, school placements often offered a restricted range of experiences, assigning heavy testing loads or clerical tasks to the student. While recognizing these legitimate reasons for university programs' reliance on university clinics, Pryzwansky criticized clinic placements because of the medical orientation prevalent in clinics, the lack of contact with school personnel, and the lack of feedback from school personnel to the student following a psychological report.

Factors contributing to the increased use of school placements probably include the greater availability of qualified on-site supervisors, the legally mandated rights of handicapped children to special education and related services, and Certification and accreditation mandates. Furthermore, as mental health and psychoeducational services became more widely available to children in

schools and community clinics, the primary purpose of university clinics changed from one of service to training and research.

In a case study of a university-based clinic in a school psychology program, Kramer and Ryabick (1981) described the training received by school psychology students in the university based clinic at Fort Hays State University. Specialist-level students completed a semester long clinic practicum before proceeding to a required school-based practicum. Advantages of the clinic practicum cited by Kramer and Ryabick included a wide base of experience, opportunity for specialized clinical experience, the provision of direct supervision of a student's initial applied experiences, the opportunity to work closely with individuals trained in a variety of specialities, and the opportunity to become active in applied research.

Despite differences in how the experience is provided, a high level of agreement exists on the need for required practicum and internship experiences, a need reflected in NASP and APA accreditation standards. In a survey of school psychology programs in 1981, Pfeiffer and Marmo found that 94 percent of programs required a practicum concurrent with coursework and that 29% of these programs placed students in a campus clinic. Brown and Minke (in press) found an increase in the experiential component of programs at both the specialist and doctoral levels between the years 1979-80 and 1981-82. With the exception of a description of one university based clinic practicum (Kramer & Ryabick, 1981), how these clinics are organized, administered, and funded, and the nature, duration, and sequencing of clinic field experiences are not addressed in the literature.

Purpose of Survey

One purpose of this paper is to describe organization and training practices of university clinics affiliated with school psychology programs. This description is based on a national telephone survey of directors of clinics that serve as practicum and internship sites for school psychology students. Results are reported both in terms of the percentages of programs reporting different practices and in terms of specific, illustrative practices in providing clinic based training experiences to school psychology students.

Method

A brief letter was mailed to the directors of the 209 school psychology programs listed in the NASP Directory of School Psychology Training Programs (Brown & Minke, 1984). The letter requested directors to complete and return a postcard questionnaire indicating if the program utilized a university based clinic as a field placement for school psychology students. Those directors answering yes were asked to give the name of the appropriate person to be interviewed regarding clinic practices as they relate to the school psychology program and to indicate whether that person was willing to be interviewed for 15-20 minutes by telephone. One letter was returned because the program no longer exists. Of the remaining 208 programs, 193 programs responded (93%). Of these 193 programs that returned the postcard, 69 (36%) have no clinic on campus; 32 (17%) do not use the on-campus clinic as a practicum site for school psychology; and 92 (48%) use a university based clinic as a field placement. Of the 92 programs reporting use of such a clinic, 71 (77%) completed the

questionnaire. Sixty of these 71 questionnaires were completed in a telephone interview, while 11 were completed by mail when the interviewee could not be reached by telephone. In most instances (72%) the interviewee was the director of the school psychology program. In some instances two persons from one program were interviewed because one person could not answer all of the questions.

Respondents were interviewed with a structured questionnaire that addressed the following areas: administration, funding, facilities, staffing, client population, coordination with other clinics on campus, contractual arrangements, supervision, multidisciplinary involvement, fees, types of field experiences, and duration and sequencing of the clinic experience. Interviewees were also asked to list their clinic's practices which they would recommend to other school psychology programs as well as their clinic's practices which they would advise other programs to avoid.

Results

Administrative and Organizational Issues. Of the 92 programs indicating use of a university clinic as a field placement for students, 47 (51%) are doctoral granting and 45 (49%) are nondoctoral granting. Given that 33% of programs listed in the NASP Directory are doctoral granting, doctoral programs are overrepresented among programs utilizing a university based clinic as a field placement ($\chi^2 = 13.47$; $df = 1$, $p < .01$).

The following results are based on the responses of the 71 programs completing the questionnarie. Doctoral training is offered by 38 (54%) of the programs. On a department level, 33% of the school psychology programs are housed in the department of psychology; 29%

are housed in the department of educational psychology; 18% are housed in the department of counseling or guidance; 9% are housed in the department of education/special education, 9% are housed in the department of school psychology, and 2% are housed in other departments. Typically (63%), programs are housed in the college or school of education; 21% are housed in the college of arts and sciences. The clinic that is used as a field placement for school psychology is housed within a single department 69% of the time, and 21% of the time it is a self-contained entity within a college. In 7% of the cases, the clinic is administered by two or more departments within a single college. One clinic (Brigham Young University) is administered jointly by departments located in two colleges, and one clinic (Winthrop College in South Carolina) is a federally administered University Affiliated Facility (UAF). The clinic at James Madison University is an entity within the College of Education that is administered jointly by the college and the State Department of Health.

Perhaps more important than the administrative arrangements of clinics that provide field experiences for school psychology students is the multidisciplinary aspect of field placements. Whereas 27 (38 %) of the clinics serve as field placements for school psychology students only, 26 (37%) provide field experiences to school psychology and other psychology student only (i.e., counseling, clinical, and neuropsychology); 5 (7%) also provide field placements to students from other psychology programs and from nonpsychology programs; and 13 (18%) provide field placements only to school psychology students and students in nonpsychology programs.

The typical clinic has been in operation for 11 or more years. Clinics in operation for fewer than five years comprised 18% of the sample. Only five clinics (7%) are accredited by any agency or governmental body, excluding program accreditation by APA, NCATE, or a similar accreditation body. In four cases the accrediting body is a state agency. Winthrop College's clinic, the only UAF clinic in our sample, is accredited by the Accreditation Council for Services for Mentally Retarded and Other Developmentally Delayed Persons, a branch of the Joint Council for Accreditaion of Hospitals.

Typically (59%) the clinic does not have a formal advisory board. When advisory boards do exist, they are usually (80%) multidisciplinary in composition, and 28% have community representation.

Usually (94%) the clinic used as a school psychology field placement is not the sole human service clinic on campus, and some coordination of services between the responding clinic and other campus clinics typically (53%) occurs. This coordination takes the form of cross referrals, division of services, sharing facilities, and use of standardized forms.

Funding. University financial support provides over 50% of the clinic's operational funds (including the estimated cost of facilities and salaries of clinic staff) for 79% of the clinics (Table 1). For 64% of clinics, university support provides over 75% of their funds. Fees generated from services (excluding fees derived from standing contracts or grants) account for over one-quarter of the clinic's operational funds for 25% of the clinics. The American International College obtains 95% of their funds from a single private benefactor, after whom the clinic is named. Larger clinics tend to be more

successful at generating extra-University funds. Those clinics whose total number of clients is above the median (see below) are more likely to depend on nonuniversity support for more than 25% of their operating funds than clinics below the median ($\underline{X}^2 = 6.48$, $\underline{df} = 1$, $\underline{p} < .05$).

Staffing. The person in charge of the clinic has the title of director in 86% of the clinics. Typically the person in the directorship is new to the position. The mode number of years in the directorship is one or fewer years, reported by 17% of the programs. Four directors indicated that the directorship rotated among faculty in programs that use the clinic. The median tenure in the clinic directorship is 5 years, with a range from 1 to 20 years. The clinic director typically has faculty status (86%), is male (65%), and has doctoral training in school psychology (56%) or clinical/counseling psychology (23%).

Interviewees were asked how many Ph.D. faculty, Ph.D. staff, graduate assistants, and administrative and paraprofessional paid positions were assigned to the clinic. Positions were computed based on full time equivalent positions. Thus, two persons who worked 20 hours in the clinic make one FTE position. Not included in calculating FTE positions are faculty who offer practicum supervision for which they receive course credit. Also not included are students who receive practicum credit for their clinic work, and secretarial positions. The mode FTE position is 0 for each staff category. The median FTE position is 0.5 for Ph.D. faculty[1], 0 for Ph.D. staff, 0.75 for graduate assistants, and 0.55 for administrative and paraprofessionals positions. Typically, clinics are administered with

very little "hired help". There are exceptions, however. Just under one-third of the clinics (n = 21) have between one and three Ph.D. faculty positions[2], 17 have between one and three nonfaculty Ph.D. positions, and 20 have between one and three administrative or paraprofessional positions. Nineteen clinics have between one and five graduate assistantship positions. Clinics with larger staffs tend to serve more than one training program or department. Two clinics have quite large staffs. The UAF clinic used as a field placement by the Winthrop College school psychology program has six Ph.D. faculty positions, fifteen nonfaculty Ph.D. positions, and twelve administrative and paraprofessional positions. The second exception is the clinic at the University of Iowa, located in the medical college hospital. This clinic is staffed with four Ph.D. faculty positions and twelve administrative assistants.

Client population. Most clinics (80%) offer psychological services for both learning and emotional/behavioral problems; 12% restrict services to the diagnosis and/or treatment of learning problems; 2% restrict services to the diagnosis and treatment of emotional or behavioral problem; and nly serve special populations such as the gifted or individuals with communication disorders. Typically (48%) the clinic serves all ages; 37% restrict services to individuals between 0 or 2 and 22 years; 12% serve only public school aged children; 1% serve only preschool age children; and 3% serve adults only.

Clinics vary greatly in the number of clients served. The mean number of clients seen in 1983-1984 is 310 (median = 150, mode = 100, range = 10-2400). The mean number of clients seen primarily for assessment is 144 (median = 60, mode = 60, range = 9-900). The mean

number of clients seen primarily for counseling is 149 (median = 20, mode = 0, range = 0-1600). The distributions for total number of clients and counseling clients are positively skewed, with a relatively few clinics seeing many clients. This situation is especially true for counseling services. Typically, a clinic either does not offer counseling services or these services are secondary to assessment services. A minority of clinics emphasize counseling services. It is reasonable to expect that clinics that serve as field placements for counseling and clinical psychology students in addition to school psychology students are more likely to offer or to emphasize counseling services. As expected, clinics that serve as feild placements for school psychology students only or for school psychology and education students are less likely to offer counseling services than are clinics that also serve as field placements for other psychology students. All but one of the thirty-one clinics that also serve as field placements for other psychology students report that counseling clients constitute more than 10% of their cases. Of the 40 clinics that serve as field placements for school psychology students only or for school psychology students and nonpsychology students only, 30 (75%) report that counseling clients constitute fewer than 10% of their cases. ($X^2 = 32.97$, $\underline{df} = 1$, $\underline{p} < .001$).

The two most common referral sources are schools and self- or parent referral, with 40% of the clinics reporting that over 30% of their clients are referred by school personnel, and 63% reporting that over 30% of their clients are self- or parent referred. These data may be misleading, because parents are often encouraged by school

personnel or others to obtain clinic services. No other single referral source typically accounts for more than 10% of referrals.

Facilities. Given the wide range in the number of clients seen in clinics, it is not surprising to find a wide range in the number of clinic rooms. The mean number of counseling and/or assessment rooms is 8.2 (median = 7, range = 0-26). The mean number of other rooms (e.g., library, equipment room, reception area, tutoring cubicles) is 4.4 (median = 3.5, range = 0-31). All but one of the clinics (i.e., the Communication Disorders Clinic affiliated with the University of Central Flordia) are located either on the university campus or on the university medical school campus.

Fees. Most clinics (n = 56, 78%) charge clients for services. Of these 56 clinics, 78% use a sliding fee scale, and 15% use a nominal fee. Of the 56 clinics charging for services, only 35% assist clients in obtaining insurance reimbursement for clinic services.

Evaluation of clinic services. Most clinics (85%) do not have a formal evaluation system in place for evaluating how well the clinic is achieving its training and service goals.

Training Issues

Number of Clinic Placements. There is a wide range in the number of school psychology students who work in the clinic in a given semester. With a range of 0-33 students for each semester, the median number of school psychology students involved in the clinic in the fall and spring semesters is 7 per semester (mode = 2), with fewer students involved in the summer (median = 2, mode = 0).

Clinic Supervision. The median number of school psychology faculty involved in clinic supervision is 2 per semester for fall and spring semesters (range = 0-15), and 1 for the summer semester (range = 0-8). Three programs (Rutgers, Ferkauf, and the University of Virginia) have arrangements for community professionals to supervise school psychology students in their clinic practica on either a voluntary or nonpaid adjunct faculty status basis. Regarding supervision, 28 (39%) programs report that school psychology students working in the clinic are supervised directly by their practicum instructor. That is, the student registers for a practicum or course that has a clinic experience component, and the student's work in the clinic is supervised by the course or practicum instructor. The clinic director or designee assigns case supervisory responsibility in 23% of the clinics. In these instances, the student may receive supervision from more than one supervisor during the field placement. The clinic director provides the direct case supervision in 9% of the clinics, and a combination of supervisory arrangements is reported by 30% of the clinics. Typically (63%) there are no formal, stated limits on the number of supervisees per supervisor. Where limits are stated, the median ratio is 4 supervisees for 1 supervisor.

Methods of compensating faculty for supervision and the percentage of programs reporting each method are as follows: supervision is in connection with a practicum that carries teaching credit (64%), a course load reduction based on the number of supervisees (24%), direct financial compensation (13%), and no compensation, or "out of faculty's hide" (20%). The percentages add to more than 100 because some programs report more than one method of compensation.

Nature of Clinic Experience. Experience in the university-based clinic is optional in 30% of the programs that have a university based clinic. In 95% of programs offering a clinic practicum or other clinic field experience, the student must also complete a school based practicum or internship.

Students first take a clinic practicum in their first year in 49% of the programs, in their second year in 34% of the programs, and in their third year in 17% of the programs. Of the programs requiring a clinic practicum, 40% require more than 200 hours of clinic experience.

The percentage of programs reporting that school psychology students render each of the listed services in the clinic are as follows: cognitive assessment (99%), educational assessment (97%), personality assessment (94%), individual counseling/therapy (57%), vocational assessment (51%), parent counseling (51%), family counseling/therapy (30%), group counseling/therapy (25%), tutoring (20%), marital counseling (19%), and diagnostic teaching (13%). School Psychology students in clinics that also involve counseling or clinical psychology students and faculty, are more likely to render counseling or therapy services than are students in clinics serving only school psychology students or school psychology students and nonpsychology students ($X^2 = 1229$, $df = 1$, $p < .001$).

Most clinics (61%) report that clinic students obtain multidisciplinary experiences through the clinic; however, cases are assigned to multidisciplinary teams in only 29% of the clinics.

Although interviewees were not specifically asked about the provision of indirect services through the clinic, many interviewees

mentioned that consultation with school personnel and other professionals was an important part of the services rendered by school psychology students in their clinic practica. In some programs students perform a consultation practicum through the clinic (e.g., National College of Education and University of Rhode Island). At New York State University the clinic's services are primarily consultative in nature and occur away from the physical facilities of the campus clinic. The clinic serves as a vehicle for arranging consultative placements. At Syracuse University, the Psychoeducation Teaching Laboratory performs comprehensive psychodiagnostic assessments of children referred by parents or schools. Before the clinic begins its assessment, the referred child's parents and significant school personnel are required to consent to participate in the consultation process with the clinic.

As seen in Table 2, clinic supervisors make use of different types of supervisory capabilities available in the clinic. Many of the supervisory methods that are reportedly used are not widely available in schools. Almost all clinics (93%) have either one-way observational windows or videotaping capabilities, and 68% have both.

Perceived Strengths and Weaknesses. To obtain interviewees' perceptions of their programs' strengths and weaknesses as related to the clinic experience, they were asked two open ended questions. (1) If a training program were considering inaugurating a university-based clinic, which of your clinic's practices would you strongly recommend to them? (2) From problems you have experienced in the past or are currently experiencing, what practices would you strongly recommend another program avoid? Of the 54 programs recommending practices, supervision practices were noted by 35, breadth of experiences

provided by 26, faculty involvement in the clinic by 17, strong university support for the clinic by 14, and multidisciplinary experiences provided by 14. Other strengths noted by more than two clinics include the public relations benefit to the university, greater involvement with parents than possible in schools, and the opportunity to emphasize the social-emotional aspects of cases instead of just the educational and academic aspects. A total of 49 (69%) programs listed perceived weaknesses. Inadequate university support was listed by 17 of the programs. Lack of faculty commitment to the clinic and inadequate clinic facilities were each named by 9 of the programs. Problems listed less frequently but more than twice include the time constraints imposed by the academic calendar and the artifical testing environment.

ILLUSTRATIVE PRACTICES

Funding: General

As noted previously, the majority of clinics are funded by a combination of university funds, typically covering facility and faculty, and fees generated, typically covering materials. Some clinics, such as Rutgers University, Ball State University and University of Pittsburg, reported being funded solely by their respective university. On the other end of the continuim, the Curtis Blake Child Development Clinic at American International College is predominately (95%) funded by a private donor. Likewise, clinics at Winthrop College, Bryn Mawr College, University of Central Florida and Florida State University illustrate various types of external funding.

The clinic at Winthrop College, (working in cooperation with University of South Carolina), is a federally sponsored University Affiliated Facility. As a regional service center, this clinic receives additional monies from state-level grants (e.g., Developmental Disabilities, Department of Social Services, Department of Mental Health, Department of Education, Autism, etc.), local community services funds, and direct state legislative appropriations. All staff positions, 15 professional and 6 support, are thus funded distinct from the College. Although designed primarily for rendering services, the Winthrop clinic is used by a number of college programs, including school psychology, as a practicum site. The clinic's Director and the Clinical Coordinators representing each discipline are given a College faculty appointment. Similarly at Bryn Mawr, the clinic is funded through contracts with local school districts (60%) and private fees (40%), and the University supplying the physical space.

The State of Florida has a number of regionalized center programs including the Department of Education's Diagnostic and Learning Resource System, The Department of Human Resources' Division of Children's Medical Services and Regional Rehabilitation Centers. The Communication Disorders Clinic, located at the Orlando Regional Medical Center, serves in the Department of Human Resources neonatal and perinatal service system. The school psychology program at the University of Central Florida utilizes this center as a practicum site. The Psychology Clinic at Florida State University serves as one of three independent clinics in the Regional Rehabilitation Center system. The University provides the facilities and one-half of the director's salary. The University also assigns a clinical

psychologist to this clinic to supervise students, offer direct services and generate referrals. In addition, seven graduate assistants are assigned to the clinic to assist in case management and to provide direct services. This practicum site serves both the clinical and school psychology programs. Fees generated, via a computerized billing system, cover one-half of the clinic's operating expenses.

The clinic at James Madison University is another example of University - other State Agency coperation. The clinic at JMU has two components: The JMU Human Development Center, funded entirely through the University; and the JMU/Shenandoah Valley Child Development Clinic, a program cooperatively funded by the University (i.e., facilities, faculty supervisory support, director) and the Viginia Department of Health (i.e., additional personnel including developmental pediatricians, psychologists, nurse, clinical social worker, and secretarial support). This cooperative program allows JMU, which is not a doctorate granting institution nor directly affiliated with a medical college, to broaden the interdisciplinary clinical training opportunities available to students of the school psychology, counseling psychology, special education, social work, nursing, speech pathology and audiology programs.

Continuity of Clinic Services

One problem in staffing cases at a training clinic is fluctuations in the availability of student clinicians and supervisors. If a practicum in individual intelligence testing is offered one semester a year, there may be too few clinic cases to meet the training needs during the semester the course is offered, and too

many referrals the next semester for the number of available clinicians. If the availability of clinic services fluctuates with course offerings, a stable referral base is difficult to achieve, and the clinic may not be viewed as a viable resource within the community. A practice used at many of the surveyed clinics is to assign graduate assistants to the university clinic. These advanced students provide a continuing stable professional service base for the clinic in addition to providing supervisory and some management services. The clinic at the University of Wisconsin at Madison employs a full time staff psychologist who provides both supervisory and direct services during the semesters but provides primarily direct services between semesters and during university vacations. This practice allows the clinic to avoid a service gap during periods when students are less available.

The Counseling and Assessment Clinic at Texas A&M University has attempted to deal with the fluctuation in available clinicians in two ways. One, all school psychology students are required to sign up for a clinic experience each semester, beginning with their second semester. During the semester, the student takes one assessment or therapy case, under appropriate supervision. Students complete the cognitive assessment course and laboratory in their first semster. At the end of each third consecutive semester, the student registers for one hour of practicum. Texas A&M's other attempt to deal with the fluctuations has been to assign cases that can not be staffed by available practicum students to students and faculty who have indicated their willingness to take cases on a fee basis. Before a student can sign up to receive these referrals, a supervisory agreement with a faculty supervisor must be on file in the clinic.

Fees generated from these cases cannot be directly forwarded to the student or supervisor, but are held in the clinic's budget and can be spent on behalf of the student and/or faculty supervisor for such professional expenditures as travel, books, and professional development. Other programs, such as Plattsburgh State University (NY) and California State University - Haywood, actually split fees (usually 50-50) with practicum students providing certain contracted services (e.g., Headstart evaluations).

As noted, the availability of appropriate faculty supervisors is also an important parameter in determining clinical training opportunities and services. Many of the survey respondents stated the need for interdisciplinary training sites, yet noted the difficulty in getting representatives or faculty from all the disciplines. Most of the clinics obtain their faculty supervisors through either direct clinical teaching assignment (which may concurrently decrease the faculty member's home department's credit hour production) or by clinic faculty supervisors being assigned a course that carries with it the clinic supervisory responsibilities (e.g., practica, assessment courses, therapy courses).

Similar to the Texas A&M faculty reimbursement for service practice, a few clinics, such as Plattsburgh State University, provide the opportunity for faculty to conduct a private practice within the clinic setting. The clinic provides the facility and secretarial support and charges the practitioner a 6% overhead fee. George Mason University (Va.) even allows what they term as consulting examiners, community professionals approved by the University, to see clients and collect fees when students or faculty are unavailable. These

arrangements are designed both to provide incentives for faculty involvement in the clinic, thus increasing opportunities for students to observe faculty in conducting assessments and interventions, and to maintain a stable work force.

The use of outside or adjunct personnel is another model used to help ensure sufficient supervisory personnel. The University of Virginia requires all of their Institute of Clinical Psychology faculty to be involved, either in direct service or supervision, with their clinic as a regular part of their faculty assignment. In addition, the University utilizes community professionals for supervision purposes in exchange for the status of adjunct affiliation with the University. Likewise, Rutgers University utilizes all 12 of its core clinical faculty in supervising clinic practica as well as 100 field supervisors. These field supervisors receive an honorarium funded through clinic fees.

Supervision

Appropriate supervision is the cornerstone for both the training and service roles of a University-based clinic. Much of the previous discussion on faculty funding delineated various models of providing supervisory staff. Further elaboration on the programs at University University of Virginia and Rutgers will illustrate the practice of combining faculty, advanced students and outside professionals in a supervisory model.

At the University of Virginia, supervision is provided by the paid clinic staff (comprised of one full time Clinical Psychologist, two one-half time Clinical Psychologists, six graduate assistants and one Ed.S. level School Psychologist), all of the Institute faculty,

nine people hired quarter time to provide specialized supervision (e.g., a professor from the medical school provides family therapy supervision), and approximately 15 community Clinical and School psychologists who denote approximately two hours per week to supervise cases. In return for their supervision, these community psychologists receive adjunct faculty status which entitles them to enjoy certain benefits, such as parking, library and continuing education privileges. Student clinicians are then teamed on cases with high level, more experienced students providing informal supervision and support to the initial level students.

The use of advanced students to supervise lower level students was found to be a common supervisory mode, especially in doctoral programs. At Rutgers, two advanced graduate students, one in Clinical and one in School psychology, are designated as senior managers of their clinic. They, in turn, each have a junior manager (lower level graduate student) assigned to them. They provide much of the clinic's management, thus freeing faculty for more in-depth supervisory activities. Students in the clinic are matched to supervisors based on the referral question and the supervisor's areas of expertise. Utilization of advanced students, faculty and field supervisors allows the students at the Rutgers clinic to receive one hour of supervision for each hour of direct clinic service rendered.

At the James Madison University Human Development Center, student clinicians receive case supervision from an assigned faculty case supervisor. Faculty, representing school psychology, counseling psychology and special education, will supervise an interdisciplinary team of students on any one case. Student clinicians thus get the opportunity to work with various faculty supervisors as supervisors

vary from case to case. Secondly, on each team of clinicians assigned to a case, the team selects someone to serve in the role of consultant. This person's role is to consult with the direct service providers concerning case progress, techniques and planning. Finally, each of the school and counseling psychology students, separate by discipline, participate in a weekly interpersonal recall supervision group that focuses on the integration of the person with the professional role.

Concerning supervisory ratios (i.e., number of clinicians that would be assigned to a supervisor unit), the survey found very few clinics that had mandated ratios (e.g., the University of Wisconsin-Stout has a university policy that sets the ratio at 10 students per supervisor). As noted previously, some programs specify a time ratio. For example, at Rutgers students receive one hour of supervision for each hour of client service, and at the University of Iowa there is a requirement that each practicum student be directly observed or taped at least four times during the semester for structured feedback. Since the issue of adequate supervision was reported as being very important to clinical training, it was even more surprising to find few clinics with specified supervisory ratios and the lack of a nationally agreed upon and professionally recognized ratio such as the ratios in the Professional Service Board accrediation standards promoted by the American Speech, Language and Hearing Association.

Although most of this section has focused on the need for adequate supervision in relaion to training, supervision is also imperative for service provision. Without service provision that satisfies the community's needs and expectations, there will not be

the continued flow of clientele necessary for training. To focus on this issue, Rutgers University has a unique Quality Assurance program in place. A faculty is assigned for one and one-half days per week to insure quality practice and provision of clinical services.

Training Experiences

Many different unique training experiences were reported within the survey format. An interdisciplinary training opportunity seemed to be a common thread through many of the described practices or was noted as a "must" if designing a clinic. Many of the interdisciplinary clinics involved a clinical setting where school psychology students could team with medical, speech and hearing, and special education personnel, often times in a medically oriented setting.

The Shenandoah Valley Child Development Clinic at JMU, the Winthrop College Human Development Center, and the University of Central Florida's affiliation with the Communication Disorders Clinic represent the efforts of non-doctorate training sites to incorporate a wider array of disciplines and services in an interdisciplinary format. At the doctorate level, the school psychology program at the University of Missouri administers four clinics, all of which are located in the neurology department of the medical school. The four clinics, i.e., School Problems, Mental Retardation and Developmental Disabilities, Learning Disabilities, and Gifted Problems, share the same facilities and are under the same coordinator, who also directs the school psychology program. Clinic cases are assigned to interdisciplinary teams with team membership varying according to the specific referral problem. The school psychology program at the University of Iowa also capitalizes on the University's medical school by placing practicum students in many of the Pediatric Psychology programs, located in the training hospital, such as the Child Development Clinic, a hospital-based school, a Learning Disabilities Clinic and a Family Therapy Clinic. It was reported that some of the school psychology doctorate students even take a minor in pediatric psychology.

Three other clinic programs are offered for review in relation to unique training aspects. The Psychoeducational Clinic of the University of Pittsburgh is a speciality clinic in the area of stress assessment systems. In their effort to avoid duplication with other existing community services, this clinic deals specifically with children exhibiting emotional based problems in schools. Using accutural measurement and interpretation and prototypic instruments

developed at the clinic, the focus is on developing intervention plans involving the home and school settings. The Learning Analysis Center of Georgia Southern College is gradually moving toward a specialty in adult learning disabilities. Finally, due to financial and staffing constraints, the West Virginia College of Graduate Studies offers its clinic only in the Summer and in cooperation with the Reading graduate program. At the beginning of the Summer, all referrals to this Reading-type clinic are given full psychoeducational assessments by school psychology students and then are seen for tutorial work by the reading program students.

In summary, the variance of training experiences seems to be based upon availability of participating training programs (i.e., students), availability and expertise of professional staff or faculty, and where one falls on the issue of whether it is preferrable to offer a wide range of services or to specialize.

Evaluation of Clinic Services

Although few formal program evaluation practices were found, the Psychoeducational Teaching Laboratory at Syracuse University offers an excellent example of evaluating clinic services. The evaluation system used by the clinic is described in two published studies (Knoff, 1982a, 1982b). The clinic accepts referrals from schools and parents in the greater Syracuse community. Recognizing that school personnel and parents share the final responsibility for the referred students, the clinic involves both consultee parties (home and school) in formative and summative evaluations of process variables and products. The formative evaluations permit trouble shooting with respect to clinic-parent or agency relationships, problem definition

processes, diagnostic conclusions and recommended interventions. The summative evaluation occurs immediately after the final consultation contact and assesses the consultee's satisfaction with the entire procedure, perceptions of change in the referred client, and changes in the consultee's attitudes, perceptions and motivations toward the referred client. A six month follow-up provides additional evidence of the success of the consultant's recommendations.

Being a part of the Virginia Department of Health's Child Development Clinic system, the JMU/Shenandoah Valley CDC participants in a systemwide computerized follow-up program. This summative evaluation program has the clinical staff note all the recommendations made at the time of final consultation with client, family and other referral agency (if one is involved). The recommendations are coded into the computer and are automatically brought up for follow-up six months after the final consultation date. The recommendations are then coded as to their status (e.g., completed, in process, service not sought, service denied, etc.). Summary reports, such as monthly or annual reports, can be generated for program decision-making purposes.

Discussion

School psychology practicum experience in a university-based clinic is a common training practice, used by 48% of school psychology programs. Doctoral programs are more likely to utilize a university-based clinic for training than are nondoctoral programs. There are many differences in how clinics are administered, funded, and staffed as well as in the extent of clinic experience required of students. Pryzwansky (1971) earlier criticized the practice of utilizing

university clinics as field placements in school psychology on the grounds that placements do not adequately prepare students to work in a school setting with school professionals. This criticism appears off-target today, because 95% of programs that place school psychology students in clinic practica also require students to do a practicum or internship in the school. The university practicum supplements rather than replaces a school placement. Perhaps the most valuable training asset offered by university-based clinics is the opportunity for faculty to closely supervise students in their initial clinical work. During the clinic practicum the student develops and refines the skills that will enable him or her to function with less direct supervision in other settings. Either one-way mirrors or videotaping are used in 92% of the clinics, and supervisory practices were mentioned as strengths by 35 programs.

Another important advantage of placing school psychology students in university clinics is the provision of training experiences not available in schools. More than half of the clinics report the availability of each of the following practicum experiences: cognitive, educational, personality, and vocational assessment, individual counseling, and parent counseling. School psychology students provide family counseling in 30% of the clinics and group counseling in 25% of the clinics. Furthermore, 26 programs specifically named breadth of experience as a strength of their clinic practicum.

It is encouraging that 61% of the programs report that school psychology students obtain multidisciplinary experiences in clinic practica, with 29% of clinics assigning cases to multidisciplinary

teams. This opportunity to work with students and faculty in counseling, clinical psychology, education, medicine, speech, and other disciplines provides students with important understandings of the role of other helping professionals.

Given the importance of program evaluation in school psychology it is disappointing that only 15% of program clinics utilize a formalized evaluation system to evaluate how well the clinic is achieving its training and service goals.

Clinics are far from self-supporting, with 64% of clinics depending on university support for over 75% of their operating funds. This funding picture suggests that clinics are viewed by departments and universities as training laboratories, justifiably supported by the involved departments' instructional funds. With tight university budgets common, the absolute level of university support for clinics can be expected to be modest. The very few paid staff positions attest to this modest absolute level of university support. Clinics that desire to expand their level or scope of training activities will need to look for non-university funds.

In the interviews with school psychology program directors, two issues that may be inherent in this model of training frequently suufaced and merit discussion. One issue is the compatability between training and service purposes. Obviously, a sufficient number of clients of a given type is necessary for school psychologists-in-training to develop and refine their clinical competencies. Problems may arise in matching clinical resources with needs defined by the case, the noncyclic nature of human services superimposed on the cyclic nature of academic semesters, and the question of quality assurance of service versus the needs of exposing students to new

situations and "stretching" them. When clinic funding is dependent on income generated, the training versus service issue may become more clouded. Service and funding considerations rather than training considerations may drive the intake and staffing processes. A second, related issue is the compatibility of faculty case supervision responsibilities with the prevailing instructional model. Many of the clinics surveyed, especially ones affiliated with nondoctoral programs, exist in systems where the prevailing instructional model is one of a lecturer with a sizeable number of students. The clinical teaching model required in a teaching clinic places considerable time demands on faculty; thus, a faculty member can teach a fewer number of students. Clinics operating in such a system may have difficulty gaining sanction and sufficient support to carry out the clinical teaching at a quality level.

A wide variety of practices and models are found in the provision of university based clinical field experiences. This variety reflects differences in program and university resources, administrative structures, program training goals, community resources, faculty interests and competencies, and the availability of alternate field placements. One commonly expressed desire on the part of interviewees was a desire for informal sharing with colleagues involved in clinic field experiences at other training programs. After the authors completed the twenty to thirty minute interview, the interviewee frequently remarked, that now he or she wanted to ask us about how our clinics operated and interfaced with our training programs. Given both the prevalence of the university clinic model of providing field experiences and the diversity of practices, a information sharing

network would serve a useful purpose. A special interest group, within NASP or Division 16 could provide such a network.

Table 1
Percentage of Clinics Obtaining Specified level of Funding from Funding Sources

% of Funding	Funding Sources			
	University	Fees for Services	Grants and Contracts	Other
0-10	5	44	81	98
11-25	8	32	3	0
26-50	9	21	7	0
51-75	15	2	3	0
76-100	64	2	5	2

Note. n = 69 because 2 clinics were unable to estimate funding levels from various sources.

Table 2
Percentage of Programs Using Supervisory Methods

Supervisory Method	% of Programs Using Method
Live	
1-way mirror no audio	16
1-way mirror with microphone	60
1-way mirror with bug-in-ear	19
1-way mirror with telephone	18
1-way mirror with intercom	54
Delayed	
Videotape	72
Audiotape	57

Footnotes

1. The authors express their gratitude to Katherine Sullivan and Stephanie Caverly for their assistance with this study.
2. Faculty FTE positions were more complicated to compute. For example, assume teaching is 50% of a faculty person's position, and a full teaching load for that position is two courses. If that person receives one course load reduction each semester for clinic work, the FTE clinic position is 0.25.
3. All positions are reported as FTE positions.

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